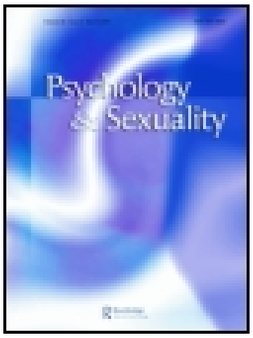

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The cost of being transgender: where socio-economic status, global health care systems, and gender identity intersect

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ABSTRACT

Around the globe, trans and gender diverse people have a wide range of access to health care, psychological as well as physical, that is unique to their home country's context. Some of the contributing factors are nations' health care systems, laws and policies surrounding discrimination, adequate resources, and under-trained health care professionals. Unfortunately, inability or difficulty in accessing transition related health care and support leads to negative impacts on mental health. In this article, the authors describe the unique contexts related to transgender health care in Canada, Japan, South Africa, and the United States. We focus specifically on the financial cost of transition for trans and gender diverse people, including gender affirming surgeries as well as mental and health care more broadly. We discuss the role of mental health professionals as advocates for gender affirming care and the fundamental human right to health care. We include discussions of therapy, assessment, medical care such as hormone replacement therapy (HRT) and surgeries, and additional invisible costs. We highlight the importance for all mental health professionals to be aware of the impacts to trans and gender diverse people's mental health when their fundamental health care needs are not met. Furthermore, we provide recommendations for how mental health professionals can advocate for their clients' access to transition related care.

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Introduction

If access to health care is a fundamental human right (World Health Organization, 1946), why is there such variance in access to transition related health care across the globe? The literature is clear that trans and gender diverse individuals experience high rates of depression and suicidality (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; McLachlan, 2019). Furthermore, the time of highest risk for suicidality for a trans or gender diverse person is when they want to medically and/or socially transition, but they are unable to (Bauer et al., 2015). Factors that impact one's ability to transition may include personal factors such as lack of social support, incidents of discrimination, or fear of rejection. Additional factors such as the medical and legal systems in one's country may inhibit a person from attaining their transition related goals. Together, these factors can create significant amounts of stress and negative mental health outcomes for trans and gender diverse people.

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The Minority Stress Model posits that experiencing, or fear of experiencing, discrimination, victimisation, and rejection related to one's identity leads to high levels of stress (Meyer, 1995). As such, minority stress is 'the mental health consequence of stigmatisation, social exclusion, discrimination, and harassment of minority groups' (The Psychological Society of Ireland, 2015, p. 19). Furthermore, experiences of 'non-affirmation' and being invalidated in society by someone's misuse of pronouns or name increases stress for trans and gender diverse individuals (Testa, Habarth, Peta, Balsam and Brockting, 2015). Minority stress is also worsened in trans and gender diverse people with multiple oppressed identities, less privilege and/or restricted access to resources (Academy of Science of South Africa, 2015; American Psychological Association [APA], 2015). Conversely, access to both medical and social transition support is protective for mental health. The TransPulse Project, a province-wide survey in Ontario, Canada, found that risk of suicidality was substantially reduced for people who were able to access transition related medical interventions such as hormone replacement therapy (HRT) and/or gender affirming surgeries (GAS; previously also referred to as sex reassignment surgery/SRS)) (Bauer et al., 2015).

It is essential for all mental health professionals to understand the contexts in which trans and gender diverse clients live and the barriers to their wellbeing. Across standards of practice for counsellors or psychologists (e.g., APA, 2015; Australian Psychological Society, 2013; Psychological Society of South Africa [PsySSA], 2017), there is little to no mention of the costs associated with health care, specifically transition-related care, for trans and gender diverse people. Around the globe, trans and gender diverse people have a wide range of access to health care, psychological as well as physical, that is unique to their home country's context (World Professional Association for Transgender Health [WPATH], 2011). Some of the contributing factors are nations' health care systems, laws and policies surrounding discrimination, adequate resources, and trained health care professionals. In some countries, HRT or gender affirming surgeries are provided through national health care plans; in other countries, any aspect of transition is completely prohibitive, whether because of societal stigma and discrimination or because of financial cost.

This paper aims to compare four countries, Canada (Ontario), Japan, South Africa, and the United States of America, three of which are 'major developed economies' according to the World Bank (2018). We selected these countries for a few reasons – first, these countries have at least some data available in English; these countries are places where some trans-affirmative work (although imperfect) is occurring; and because we wanted some kind of diversity across continents. This manuscript does not provide an exhaustive comparison of countries around the world, but provides a start for the reader to understand the global context. For each country's context, we provide background, a description of access to care (or lack thereof), and the role of mental health providers. Where possible, we provide comparisons of access and cost, but because of the unique context of each country, this is not always possible. We focus specifically on the financial cost of transition for trans and gender diverse people and mental and health care more broadly. We discuss the role of mental health professionals as advocates for gender affirmative care and the fundamental human right to health care, including therapy, assessment, medical care such as HRT and GAS, and additional costs, some of which are 'invisible' or difficult to measure. Trans affirmative care has been defined as practices that are respectful, aware, and supportive of trans identities and life experiences (Korell & Lorah, 2007); we assert that this must include awareness of real financial costs and advocacy for better policies. Throughout the article, we use the term gender affirmative to include all trans and gender diverse identities.

The goal of this paper is to highlight to mental health care providers that it is essential to understand the socio and political context in which they are practicing and how it directly impacts the lives of trans and gender diverse clients/patients. We also aim to inform the reader of the real inconsistency across the globe in trans-affirmative practice; although we only highlight four countries, the differences are great and we imagine they must be significant if including other countries. We provide recommendations for psychologists and other health care professionals in

improving access to health care for transgender and gender diverse people in international contexts. This review, although limited to four countries, is the first of its kind to examine the real-life financial costs for trans and gender diverse people. Please note that all costs and conversion rates were accurate as of May, 2019.

Canada: Ontario

Background

In Canada, funding for GAS is organised at a provincial and territorial level. Therefore, there is no standard across the nation. This section will describe the current landscape and process to access transition related health care and GAS for the province of Ontario and Ontarians. In Ontario, a person can legally change their name for $137 CAD on their identification such as birth certificate, driver's license and passport. There is no financial cost to legally change one's sex designation (Male, Female, or X) however it requires a letter from a physician or psychologist to advocate that the sex designation a person was assigned at birth does not fit their gender identity. As of 2016, sex designation no longer appears on Ontario health cards, which is the piece of identification that allows access to health care practitioners and hospital visits.

Prior to 2016, all Ontarians accessing government funding for their GAS, were required to be assessed at the Adult Gender Identity Clinic at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario. Therefore, regardless of the presence or absence of any mental health or substance use concern, all trans and gender diverse people required a psychiatric assessment from either a Psychiatrist or Psychologist. Significant barriers existed, including long wait times and the requirement for assessment at a mental health hospital regardless of a person's mental health status. With much advocacy from numerous groups, including CAMH, Ontario's Ministry of Health and Long-Term Care (MOHLTC) changed the regulation in March 2016 (Ontario Ministry of Health and Long Term Care, 2016). This change allowed for funding referrals to come from Primary Care Providers including Physicians, Nurse Practitioners, Registered Nurses, Psychologists, and Master Level Social Workers (Ontario MOHLTC, 2016). As seen in Figure 1, this led to a drastic increase in

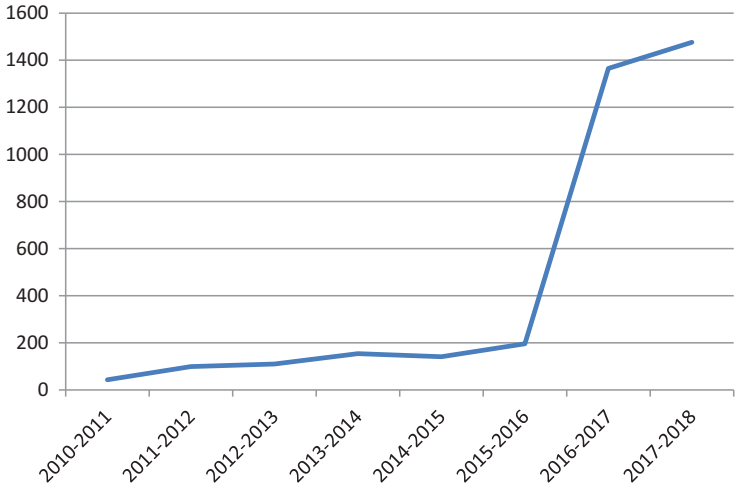

Figure 1. Number of surgeries funded by the MOHLTC in Ontario per year.

Table 1. Funded surgeries by the MOHLTC in Ontario.

	Feminising Surgeries	Masculinising surgeries
Available in province	Orchiectomy Scrotectomy Breast Augmentation (only if breast growth is under Tanner stage 1 after 12 months of HRT)	Mastectomy and chest contouring Hysterectomy Erectile device Scrotal implants
Require out of province travel	Vaginoplasty Vulvaplasty	Phalloplasty Metoidioplasty Clitoral release

the number of trans and gender diverse people who were able to access government funding for their surgeries.

Access to care

Many barriers to social and medical transition exist for Ontarians. As seen in Table 1, HRT, voice therapy or surgery, electrolysis or laser hair removal and in most cases, breast augmentation surgery are not funded. Furthermore, there is a scarcity of surgeons who are trans affirming and provide GAS. At this moment, there is only one surgical centre in Canada where vaginoplasty, phalloplasty, metoidioplasty, and clitoral release are performed. All Ontarians who require these surgeries need to travel out of province or out of country. Travel costs, accommodation, food, supplies, and any post-discharge nursing care are not funded by MOHLTC for out of country surgeries. This can mean substantial out of pocket costs, especially in the case of a post-surgical complication when travel needs to occur quickly. The surgeries that are available in the province of Ontario include orchiectomies, hysterectomies, breast augmentation and masculinising chest surgery. However, masculinising chest surgeries are not fully funded and the out of pocket costs range from $1,500 to $3,000 CAD. Masculinising chest surgeries are more readily available by a variety of surgeons, but not all surgeons at the moment are trans affirming.

In order to be funded for GAS, a person must meet the WPATH's Standards of Care, Version 7 (SOC7) (WPATH, 2011). A person must have access to a trans affirming primary care provider who is knowledgeable about the WPATH SOC7 (2011) eligibility and readiness criteria and who can advocate for the surgery funding. The following surgeries are covered by MOHLTC.

Role of mental health providers

In Ontario, Physicians, Nurse Practitioners, Psychologists Registered Nurses and Master Level Social Workers are able to refer clients for funding for GAS. All clinicians must be versed in the WPATH SOC7 (World Professional Association for Transgender Health (WPATH), 2011). A formal diagnosis of gender dysphoria is part of the WPATH eligibility criteria. As such, Physicians, Nurse Practitioners and Psychologists are able to make this diagnosis. All funding requests require at least one physician or nurse practitioner. For gonadal and genital surgeries, two independent assessments are needed, one being from a physician or nurse practitioner and the second from any of the five types of care providers listed above.

Unfortunately, not all health care providers learn how to provide trans affirming care during their training. Many are practicing health care without knowledge of HRT, GAS and the specific health care and mental health care needs of trans and gender diverse people. Training programmes do exist for specialised transition related care training via Rainbow Health Ontario (https://www.rainbowhealthontario.ca). CAMH is also providing case-based trainings to help

increase health care provider confidence and competence in referring clients to funded GAS. Overall, the landscape for accessing funded GAS in Ontario is improving and increasing, however there is still room for improvement until every health care provider is trans affirming.

Japan

Background

It is important to note that information on Japan, compared to the other countries we describe, is limited due to the fact that most data and publications are not available in English. Compared to some countries in Asia, Japan is fairly socially progressive. In fact, gender diverse people in the region often think of Japan as a safer place in which to live or transition based on the fact that Japan has many gender diverse celebrities and pop stars who are celebrated there (Fifield & Oda, 2015). Discrimination based on sexual orientation and gender identity is banned in cities such as Tokyo (Human Rights Watch, 2018). Japan's Ministry of Education and federal government have been taking steps towards protecting transgender and gender diverse students through uniform policy changes and bullying prevention (Human Rights Watch, 2018), and Japan has banned conversion therapy. However, an alternative view is that Japan is still largely a homophobic and transphobic society and there are major issues with discrimination on a daily basis (Amnesty International, 2017; Kaleidoscope Human Rights Foundation, 2015). The first GAS in Japan was completed in 1998 (Ako et al., 2001). In Japan, 'Gender Identity Disorder' is still considered a mental illness according to Mental Health and Welfare Law (Masumori, 2012). In 2003, legislation allowing for medical treatment for Gender Identity Disorder was passed, approving legal sex change (Doi & Knight, 2017). As of 2016, approximately 7,000 people in Japan have legally changed their sex status (Kyodo, 2017). Japanese law also allows people with gender dysphoria to have their preferred names on their national insurance cards if they submit documentation from their physician (The Japan Times, 2018).

It is possible for Japanese citizens to change their gender markers. This requires recommendations of two physicians (Kyodo, 2017). In addition, according to Japan's Law 111, people who wish to make this change must be 20 years of age; must be single; must not have children under the age of 20; and must have had a sterilisation surgery to remove their uterus or testicles (Hurst, 2018). These requirements are quite controversial in Japan, as young people are rushing to engage in sterilisation surgery to qualify for gender marker changes (Doi & Knught, 2017; Hurst, 2018). This forced sterilisation requirement seems to violate several human rights (Hurst, 2018).

Access to care

In Japan, the wait for an appointment with a therapist with expertise in gender-related issues is approximately three months (Kyodo, 2017). The cost of this therapy, typically consisting of weekly 15-minute sessions, is covered by the national health care system, however. HRT in Japan requires two letters of recommendation from physicians and is not covered by Japan's national health care system (Kyodo, 2017). HRT generally costs about 1700 yen per week or about $1067 CAD per year.

GAS is possible in five hospitals throughout the country of Japan and a few small clinics. Typically there is a wait list of at least six months for assessment and diagnosis, and patients may wait up to three to four years to schedule the surgery (Kyodo, 2017). Until recently, the cost of surgery was not covered by Japan's health care system and costs ranged from $17,000 CAD to $24,000 CAD. Because of the prohibitive costs, many Japanese people who wish to have GAS will travel to Thailand for care. Recent legislation, which went into effect in April 2018, will provide some coverage for GAS, so that patients will only be responsible for 10–30% of the total costs. However, there is a ceiling on the amount that is reimbursable, and for many, even 30% of $18,000 ($24,252 CAD) is impossible to afford.

Role of mental health providers

Unfortunately, there is little information available in English on the role of mental health providers in work specifically with trans or gender diverse persons in Japan. There are several mental health professional organisations in Japan, such as International Mental Health Professionals Japan and the Japanese Psychological Association, and there are active non-governmental organisations throughout Japan, such as LGBT Youth Japan and Stonewall Japan, that promote LGBTIQA+ advocacy. However, it does not appear that these organisations have developed guidelines specifically for work with transgender or gender diverse people.

South Africa

Background

South Africa is known for one of the most progressive Constitutions and Human Rights legislation, in the world. In the African continent, South Africa is the only country advancing gender and sexual orientation rights (Oberth, 2014). The South African Constitution (Republic of South Africa, 1996) includes equality also in the areas of gender, sex, and sexual orientation. Through socio-legal reform and policies, respect for diversity is propagated (PsySSA, 2017) and the laws are regarded as advanced regarding the legal emancipation of LGBTIQA+ individuals (Klein, 2008). For example, in South Africa, a trans or gender diverse person can change their legal gender marker by providing two letters from their physicians or health care providers stating that they are undergoing gender affirming treatment (cost $8 CAD). Although it is often mis-interpreted that a trans or gender diverse person should have had GAS, this is not the case. The trans and gender diverse person only needs to access gender affirming treatment, for example, use HRT, in order to qualify for this provision (Gender DynamiX & Legal Resource Centre, 2014). The trans and gender diverse person is also able to change their given name to their preferred name (cost $8 CAD).

In South Africa the Western binary concept is still firmly upheld. People who do not see themselves as either male or female find themselves in a position where they have to subscribe to one of the two genders. A research study conducted by The Other Foundation (2016) indicated that over 3 million of the 58 million people in South Africa, presented as gender non-conforming. Health care providers are also experiencing high numbers of people who identify as transgender and are requesting gender affirming health care. Trans as a gender identity is becoming more known within the social context, and even in the more rural communities, people are coming forward attempting to access gender affirming health care. But no l epidemiological study has been conducted to establish the prevalence of gender dysphoria in South Africa (McLachlan, 2019).

South Africa has a diverse population with different cultures and races as well as religious ideas. People live in urban, peri-urban, and rural areas and South Africa has one of the most inequitable societies when it comes to financial stability. In certain areas and provinces in South Africa it is more acceptable to be trans or gender diverse and in each segment of the population the attitude can vary (McLachlan & Nel, 2018). It is a country of diversity and extremes. Although the human rights in South Africa are very progressive, trans and gender diverse people still experience intimidation, stigmatisation, marginalisation, violence and even hate-crimes (Nel, Van Wyk, & Mbatha, 2013).

Access to care

For most trans and gender diverse people in South Africa it is challenging to access gender affirming health care. In public health care only two clinics exist that specialise in trans health care, offering HRT and most gender affirming surgeries. One is in Cape Town, Western Cape, at the Groote Schuur Hospital, and the other is in Pretoria at the Steve Biko Academic Hospital (Wilson,

Marais, De Villiers, Addinall, & Campbell, 2014). Some other public hospitals do offer services but they do not necessarily have a dedicated trans service consisting of a multi-disciplinary team. In at least four of the nine provinces, transgender people can access HRT in public health care. Most of these services require a diagnosis of gender dysphoria and do not assist gender diverse people who do not experience gender dysphoria but who still need access to health care services.

Furthermore, not all the hospitals subscribe to the WPATH SOC7 (World Professional Association for Transgender Health (WPATH), 2011) and some use much older versions. Only an endocrinologist is able to prescribe hormones in public health care. Most endocrinologists do not work in public health and are mainly placed in urban areas. It thus becomes very challenging for trans and gender diverse people in rural areas to access health care (Wilson et al., 2014). In public health care the cost of services works on a sliding scale according to a person's income. An unemployed person can mostly access health care for free. There are also different costs involved regarding the various surgeries in the different provinces. In certain provinces the unemployed person can access GAS for free whereas in other provinces there is a nominal fee involved. The waiting list at the public health institutions are long, over 25 years at Grootte Schuur Hospital, and only offered in four provinces (McLachlan & Nel, 2018).

As previously mentioned, public health care is based on a person's income. For example, an unemployed person can access all health care for free. A person in the second lowest bracket will pay R80 (CAD $7) all inclusive, when consulting an endocrinologist, for the blood tests, and HRT medication.

In private health care, Gender DynamiX, a Non-Profit Organisation focusing on trans and gender diverse people's needs, has developed a hormone protocol that can be used by General Practitioners (De Villiers & De Vries, 2013). Gender DynamiX has also trained over 200 health care workers in gender affirming health care. The protocol is based on an informed consent model. This has enabled trans and gender diverse people to access gender affirming hormones. But medical aids (medical insurance) do usually not pay for this treatment and the majority of people in South Africa cannot afford private health care (McLachlan, 2019). Only 18% of the 55.91 million citizens in South Africa are members of a medical aid (private health care). Only two top plans of one of the medical aids cover GAS and HRT. There have been a few individual cases where other medical aids have covered GAS and HRT. GAS is costly and only a few surgeons offer, and are skilled to offer, care to trans and gender diverse patients. For many trans and gender diverse people, the possibility of accessing GAS is unlikely (Wilson et al., 2014).

Gender affirming private health care is not easily accessible in South Africa. It is also costly and unaffordable for most people seeking trans health care (please see Table 2). Furthermore, due to the lack of training related to trans health care for health care providers, most health care providers are unable to provide gender affirming health care (Müller, 2013). Transphobia within the medical field adds further barriers to accessing health care (Jacob & Cox, 2017). The medical model tends to be paternalistic leading to strong gate-keeping in certain areas of medical provision (McLachlan, 2019).

The Psychological Society of South Africa (PsySSA) *Practice Guidelines for Psychology Professionals Working with Sexually- and Gender Diverse People* state: 'Intersectionality in psychology, as a concept, acknowledges diversity and focuses on attending to all the different forms of oppressions that occur in society – the different "-isms" – racism, ableism, heterosexism, sexism, classism,

Table 2. Availability of GAS in public health in South Africa.

	Feminising Surgeries	Masculinising surgeries
Available in 5 provinces		Mastectomy
Available in 4 provinces	Vaginoplasty	Phalloplasty
Available in 3 provinces	Orchiectomy	Metoidioplasty
	Vulvoplasty	Clitoral release
	Scrotectomy	Scrotal implants
	Breast Augmentation (not readily available)	Hysterectomy

etc. and the ways they overlap and often reinforce a power that could potentially subjugate one cultural group.' (Psychological Society of South Africa (PsySSA), 2017, p. 4). Most trans and gender diverse people in South Africa experience various forms of oppression (Klein, 2013; Sanger, 2014). These challenges not only add to minority stress but also to trans and gender diverse persons' ability to access gender affirming health care (Psychological Society of South Africa (PsySSA), 2017).

Role of mental health providers

In KwaZulu Natal, one of the provinces in South Africa, a participatory approach was developed for trans people and practitioners (McLachlan, 2019). In this approach the mental health worker explores with the trans and gender diverse person the development of their gender identity, as well as the reasons for wanting to access gender affirming care (McLachlan & Nel, 2018). The psychologist moves away from a gatekeeper role to a space where the psychologist accompanies the person on their journey (McLachlan, 2019). Through attending trainings with health care providers, the trans and gender diverse person takes ownership and responsibility of their journey. Support groups also create spaces where participants not only emotionally support one another, but also share practical information. Trans and gender diverse people become ambassadors in their lived world where they challenge systems and educate their community (McLachlan & Nel, 2018). The mental health provider provides support and treats, when necessary, mental health challenges. Gender diversity is not seen as a pathology but just as different representations of diverse identities (McLachlan, 2019).

The mental health provider also uses an affirmative stance and advocates for their client (Psychological Society of South Africa (PsySSA), 2017). Often the mental health provider becomes actively involved in policy development, research, training, and advocacy (McLachlan & Nel, 2018). PsySSA (2017) has developed Practice Guidelines for Psychological Professionals who work in the field of sexual and gender diversity. These guidelines speak to working in the field of trans health care and are becoming an important guide for not only psychological professionals but also other health care professionals (McLachlan & Nel, 2018).

United States

Background

It would be a disservice to begin a section on access to care for transgender individuals in the United States without acknowledging the mass genocide of First Nation and Indigenous peoples, and with it the erasure of gender diverse and two-spirit individuals within these populations (Beemyn, 2014; Smith, 2005). It is difficult to estimate the actual percentage of trans and gender diverse folks as a result of this violence. The most recent surveyors estimate that between 0.53% (Crissman, Berger, Graham, & Dalton, 2017) and 0.6% of adults identify as transgender (Flores, Herman, Gates, & Brown, 2016) in the United States. However, this number is likely an underestimate due to the many trans and gender diverse people who are 'in the closet,' in addition to this being a hard to reach population (James et al., 2016).

Many barriers to transition-related care in the United States exist because of economic inequality. Broadly, 29% of participants in the National Transgender Discrimination Survey (NTDS) lived below the poverty line in the United States, and 15% were unemployed at the time of the study (James et al., 2016). Researchers of a 2002 study found economic discrimination to be the strongest predictor of experiencing violence, and trans adults of low income status were significantly more likely to experience discrimination (Lombardi, 2002). Trans and gender diverse people with incomes over $50,000 USD ($67,000 CAD) (were significantly more likely (76%) to receive mental health treatment than those with income less than $10,000 USD ($13,000 CAD) (48%) (James et al., 2016).

Access to care

A key factor that contributes to the economic disparity in the United States is health insurance. Although most states have surgeons and physicians who will perform GAS and prescribe hormones, coverage of these costs depends on each individual's health insurance status. Due to no universal health care system in the United States, policies on trans and gender diverse related care vary widely based on private, public, or employer-based coverage. According to researchers of the most updated NTDS, 19% of transgender individuals do not have health insurance, and 51% had employer-based insurance (James et al., 2016). Southern areas of the country (Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Florida, Georgia, South Carolina, North Carolina, Virginia, Tennessee, and Kentucky) had the greatest disparities in insurance coverage, with 25% of respondents having no insurance, 17% public, and 59% private (James et al., 2016). The impact of insurance coverage for trans and gender diverse people is significant. Trans and gender diverse individuals without insurance are five times more likely to delay seeking care than those with private insurance (Cruz, 2014). Gender dysphoria is often not covered by insurance for those seeking mental health treatment, which creates an additional barrier to mental health and transition related medical services (Khan, 2011; Stroumsa, 2014). For an individual in the United States who does not have health insurance, direct, indirect, and invisible costs (such as depression, drugs and alcohol use, chronic medical conditions, and job loss) of transition could total between $15,000 USD ($20,000 CAD) for transgender men and $26,000 USD ($35,000 CAD) for transgender women who receive GAS (Padula, Heru, & Campbell, 2016). Transgender men and women who have insurance and receive GAS, however, may accrue closer to $9,000 USD ($12,000 CAD) in direct, indirect, and invisible transition related costs (Padula et al., 2016). One United States-based author of this article spoke to a transgender man with employer-sponsored health insurance through a major insurance provider and a summary of his costs and insurance coverage is provided in Table 3 below as a case study example.

Insurance policies also create unique considerations for trans and gender diverse individuals in the United States who wish to change their gender markers. For example, under some insurance policies, transgender men lose insurance coverage of mammograms and Pap smears if they change their gender marker to male (Aiken, 2016). Similarly, transgender women often lose coverage of

Table 3. Selected costs in South Africa in South African Rand (and approximate Canadian dollars) – (Private health care).

	Feminising	Masculinising
Hormone	Estrofen or Premarin = R750-1300 per month (CAD $72–125) Spironoclatone (Blocker) = R350 per month (CAD $34)	Depot Testosterone = R250-800 (CAD $ 24–78) per month
Lab	ALT + Total cholesterol + Potassium & Creatinine = R350 (CAD $34) Finger-prick glucose – done at practice/ pharmacy HIV test – free at clinics If cholesterol raised may need full lipid profile = R550 (CAD $54) pm Hormone levels not routinely done but may be indicated in certain situations	ALT + Total cholesterol + Full blood count (no plt) = R400 (CAD $39)
Surgery (hospital + anaesthetist + surgeon)	Orchidectomy/Orchiectomy = R10 000+ (CAD $1,000+) Vaginoplasty = R160 000+ (CAD $15,400+)	Mastectomy = R65 000+ (CAD $6,200+) Phalloplasty = R200 000+ (CAD $19,200+)
Other costs may include (amongst many others)	Dilators Electrolysis/hair removal Physio – pelvic floor	Stand To Pee = R1000+ (CAD $96+) Binders R450+ (CAD $43+) Packers = R750+ (CAD $72+)
Gender marker and name change	R140 (CAD $13)	

prostrate exams if they change their gender marker to female (Aiken, 2016). This often leaves trans and gender diverse individuals in the position to decide between having a gender marker that does reflect their identity, or experience continued discrimination and limited access to necessary health care (Aiken, 2016; Bazzi, Whorms, King, & Potter, 2015).

This disparity in income and insurance coverage in the United States has a direct effect on access to mental health care and medical care. The WPATH SOC7(World Professional Association for Transgender Health (WPATH), 2011), which is followed by many physicians and mental health professionals in the United States, recommends psychotherapy services before surgical treatment (Coleman et al., 2012). However, as both United States-based authors have experienced, and many clients have reported anecdotally, some surgeons will require six months of psychotherapy services prior to surgery, especially if the patient is not taking HRT The inequality of income and insurance coverage creates a natural barrier for trans and gender diverse individuals to access services necessary to pursue their medical transition. Barriers to health care and health-harming behaviours, such as substance abuse and smoking, were found to contribute to transgender individuals delaying transition-related care, including medical interventions (Hendricks & Testa, 2012). These barriers all contribute to a systemic issue to accessing care in the Unites States for many trans gender diverse people of low income and low socioeconomic status.

Due to the structure of government in the United States, a trans and gender diverse person's experience of access to care, coverage of transition-related costs, and policies regarding social transition varies significantly from state to state. However, across the country, access to health care and basic needs such as employment and housing are dependent on identity documentation that matches an individual's gender (James et al., 2016). Forty percent of responders in the NTDS reported experiencing harassment when their government-issued identification did not match their gender (James et al., 2016). Those with identification that matched their gender had high rates of accessing doctors' offices for medical care (James et al., 2016). In general, trans and gender diverse individuals are less able to access mental health or medical health care services due to difficulty in attaining proper and congruent legal identification (Roller, Sedlak, & Draucker, 2015). Currently, eleven states require proof of surgery to change the gender marker on a driver's license: Alabama, Georgia, Iowa, Kentucky, Louisiana, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Wyoming (Christian, 2018). Nine states and territories have unknown, unwritten, or unclear policies: Arkansas, Mississippi, Montana, North Dakota, South Dakota, American Samoa, Guam, Northern Marianas Island, and the U.S. Virgin Islands. Only Oregon, California, Massachusetts, Nevada, and the District of Columbia do not require a licensed provider to certify the individual's identity (Christian, 2018).

Due to the variances in cost and coverage based on state differences and insurance policies, an average of costs is provided in Table 4. Transition related costs were collected and averaged from informal client reports at the Dennis R. Neill Equality Centre in Tulsa, Oklahoma, along with case studies found in the literature (Herman, 2013; Horton, 2008; Padula et al., 2016). In developing this table, individuals with lower socioeconomic status were assumed to have no insurance and individuals with high socioeconomic status were assumed to have health insurance. This was done for a few reasons; first, because insurance coverage plays a critical role in access to health care for trans and gender diverse individuals, as discussed above. Second, insurance options for

Table 4. Case example of insurance coverage of transition-related services in United States for a transgender man (in USD and CAD) (*Note 'copay' in the United States refers to the amount that the individual is required to pay out-of-pocket.).

	Employee Costs	Yearly Total
Hormones (testosterone)	$10 ($15 CAD) copay	$120 ($160 CAD)
Biyearly labs	$25 ($35 CAD) copay	$50 ($70 CAD)
Top surgery (Mastectomy)	20% of surgery total	$1500 ($2,000 CAD)
Mental Health Services	$30 ($40 CAD) copay	$720 ($970 CAD)

Table 5. Approximate costs in United States (in USD and CAD) (Not inclusive of all possible surgeries.).

	Low SES Transgender Man	High SES Transgender Man		Low SES Transgender Woman	High SES Transgender Woman
Direct Costs			**Direct Costs**		
Top Surgery (Mastectomy)	$7,000 ($9,500 CAD)	$2,000 ($2,700 CAD)	Bottom Surgery (Vaginoplasty)	$23,000 ($31,000 CAD)	$7,000 ($9,400 CAD)
Hormones	$720 ($970 CAD)	$230 ($310 CAD)	Hormones	$2,370 ($3,200 CAD)	$500 ($673 CAD)
Indirect Costs			**Indirect Costs**		
Insurance	$0	$2,175 ($2,930 CAD)	Voice Lessons	$550 ($741 CAD)	$2,000 ($2,700 CAD)
Binders/Prosthetics	$200 ($270 CAD)	$550 ($740 CAD)	Wardrobe/Makeup	$300 ($404 CAD)	$1,200 ($1,616 CAD)
Mental Health Services	$1,100 ($1,482 CAD)	$720 ($970 CAD)	Mental Health Services	$3,000 ($4,042 CAD)	$1,000 ($1,347 CAD)
Transportation	$3,000 ($4,042 CAD)	$1,200 ($1,616 CAD)	Transportation	$3,000 ($4,042 CAD)	$1,200 ($1,606 CAD)
Legal Fees (e.g., name change)	$200 ($270 CAD)	$200 ($270 CAD)	Legal Fees (e.g., name change)	$200 ($270 CAD)	$200 ($270 CAD)
Invisible Costs			**Invisible Costs**		
Job Discrimination	$565 ($761 CAD)	$0	Job Discrimination	$1,130 ($1,522 CAD)	$0
Housing Discrimination	$900 ($1,212 CAD)	$0	Housing Discrimination	$2,000 ($2,700 CAD)	$0
Secondary Medical Costs	$11,000 ($14,820 CAD)	$4,000 ($5,389 CAD)	Secondary Medical Costs	$14,000 ($18,863 CAD)	$5,000 ($6,737 CAD)
Yearly total w/one-time surgeries	$24,685 ($33,170 CAD)	$11,075 ($14,922 CAD)	Total w/one-time surgeries	$49,550 ($66,761 CAD)	$15,900 ($21,423 CAD)
Yearly total w/o one-time surgeries	$17,685 ($23,828 CAD)	$9,075 ($12,227 CAD)	Total w/o one-time surgeries	$26,550 ($35,772 CAD)	$8,900 ($11,991 CAD)

low-income individuals in the United States, like Medicaid, have been cut and expansion has been rejected (Sommers, Atul, Gawande, & Baiker, 2017). This is especially true in southern states where uninsured rates are already the highest (Sommers, Blendon, Orav, & Epstein, 2016). There is a strong relationship between lower income and uninsured status, suggesting that those without insurance are likely in the lowest income bracket and have the fewest options to accessing medical and mental health care (McWilliams, 2009; Sommers et al., 2016). Finally, those of a lower socioeconomic status who have insurance have better health outcomes as they report increased access and utilisation of care, improved financial security, decreased reports of depression, and improved reports of health compared to individuals of lower socioeconomic status who do not have insurance (Sommers et al., 2017). Therefore, examining transition related costs accrued by trans or gender diverse individuals of lower income status and without insurance provides a better look at socioeconomic disparities within the United States. Monetary expenses related to insurance, discrimination, and other invisible costs were estimated using utility data and cost per quality-adjusted life year (QALY) estimates for depression, drugs and alcohol use, chronic medical conditions, and job loss (Padula et al., 2016). Approximate costs across the United States are provided in Table 5.

Role of mental health providers

For mental health professionals in the United States, there are a few implications for practice. First, providers have an ethical obligation to provide low-cost or pro-bono services to their trans and gender diverse clients, particularly for those who have low income or are in areas of the country where services are sparse. Second, it is important that mental health professionals know the resources available for their clients that could minimise the direct and indirect costs of transition. For example, providers should have knowledge about the local organisations that might have a clothing or binder exchange for transgender individuals, or what endocrinologists provide hormone therapy for transgender clients. Third, it is imperative that providers know the laws and policies that impact their trans and gender diverse clients in their state and community. This includes the process of changing names and gender markers on legal documents, seeking gender affirming surgeries, and/or protections that exists to protect trans individuals from discrimination. This familiarity arms those in helping professions with information to advocate for clients and minimise the impact of the high, invisible costs that result from discrimination.

Comparison across contexts

A comparison across these four nations is provided in Table 6 below to synthesise the information that has been given thus far. Some commonalities between all four countries:

- Trans and gender diverse individuals face stigma, discrimination, and rejection within health care systems.
- Policies and availability, as well as costs, differ between different provinces in the countries. There is not one consistent policy covering access to gender affirming health care within the country except in Japan.
- Access to mental health and physical health care in all of the four countries is limited but improving.
- WPATH guidelines are mostly incorporated, or at least acknowledged, in gender affirming health care in the four countries.
- Mental health care providers can play an active role in gender affirming treatment.
- Access to gender affirming health care, and the costs thereof differ not only between the different countries, but also between the different provinces within the countries.

Table 6. A comparison across contexts.

	Requirements to change gender marker	Insurance Coverage	Estimated Costs (CAD)	Surgery Accessibility	Additional Limitations
Canada	Letter from a physician or psychologist	Some psychotherapy; Orchiectomy, Hysterectomy, Vaginoplasty, Phalloplasty, Metoidioplasty, and clitoral release; few breast augmentations; partial funding for mastectomies	Name change: $137 Top surgery: $1500–3000	Vaginoplasty, Phalloplasty, Metoidioplasty, and clitoral release only available at one surgery centre in Canada	Mental health professionals need additional training; many surgeons are still not gender affirming for trans and gender diverse people
Japan	Surgery resulting in 'forced sterilisation' required. Additional criteria such as single relationship status and not having children under the age of 20	Therapy	HRT: $1,067 GAS: $5,000–7,000	All surgeries only available in five hospitals; many travel to Thailand	Gender Identity Disorder still considered a mental illness and there are no guidelines for working with trans and gender diverse individuals
South Africa	Two letters from physician or health care provider confirming gender affirming treatment (such as HRT)	Medical Aid (Private health care) One Medical Aid's top two plans and other plans or Medical Aids on a case to case basis. Public health care: Depending on province and income bracket (percentage covered)	Gender marker/name change: $13 HRT: $288–1,500 Top Surgery: $6,200+ Bottom Surgery: $15,400+	Two specific clinics (public health care) for trans health care; other hospitals provide trans services but are not always trans affirming; surgery wait time at public institutions are over 25 years With private health, varies between provinces depending on surgeon availability	Only endocrinologists can provide hormones in public health. (With private health, can be prescribed by other doctors)
United States	Varies by state; up to 13 still require proof of surgery, 14 require certification from a licensed health care or mental health professional	Coverage varies by insurance status; most employer-sponsored and private insurance policies offer HRT and psychotherapy coverage with a copay and up to 80% of GAS surgery	Without insurance: Gender marker/ name change: $270 HRT: $970–3,200 Top Surgery: $7,000 Bottom Surgery: $31,000	Many surgeons provide GAS, but vary on the requirements and some do not follow WPATH Standards.	Access and affirming care varies drastically depending on state, and no federal policy exists for trans and gender diverse individuals to create consistency

Summary and conclusions

In this review, we highlighted the unique national contexts of four countries, Canada, Japan, South Africa, and the United States. We established the need to examine the financial costs, access and barriers to health care, and the role of mental health providers. It is important to note that three of the four countries represented in this review, Canada (Ontario), Japan, and the United States, are considered 'major developed economies' according to the World Bank (2018). South Africa is unique within the African continent as having developed progressive guidelines for psychologists who work with sexually- and gender diverse clients (Psychological Society of South Africa (PsySSA), 2017). Around the globe, however, there are many countries where the notion of transition may be an impossibility for its citizens, not only due to financial costs, but due to stigma, discrimination, and personal safety. For example, to lesbian/gay/bisexual expression (which may include gender diverse expression) may incur criminal penalties in countries such as Yemen or Malaysia (International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2017). Therefore, these four countries should not be seen as representative of the experiences of trans and gender diverse people more globally. Also, we want to note that there continues to be discrimination and structural inequities in these four countries, so they should not be looked to as a model or 'gold standard' for care.

From the review, a clear message emerges: The high cost and difficulty to access health care for trans and gender diverse people can impact trans and gender diverse person's mental and physical health. For people already living in poverty, steps needed for social or medical gender affirmation may be an impossibility if not subsidised in some way via national health care systems or health insurance. The high costs of transition-related health care may further contribute to poverty, homelessness, and risky behaviours, such as ordering HRT through the internet rather than receiving a prescription from a physician.

In all settings, mental health providers need more training at the university/professional level related to trans and gender diverse persons' health. Mental health providers need to be aware that policies and laws are created in the context of social acceptance, regardless of geographic location. Therefore, those in a helping profession must educate themselves on how these policies, legislation, and societal culture protect or discriminate against trans and gender diverse folks, and actively work to support this population. Mental health providers must play a stronger role moving forward in advocating for change, based on their understandings of structural discrimination, institutional oppression, and health policy. They can use their knowledge and training to advocate for policy and legislation changes to support free or low-cost services. Mental health providers may provide low-cost or pro bono services or may provide low-cost support via therapy groups. They may use creative methods such as working with local non-governmental organisations or non-profit agencies to organise clothing swaps for trans and gender diverse people, for example. They should be aware of local resources and the laws and policies that govern trans people in their region. Mental health providers may also engage in training a new generation of competent providers – gender affirmative practice should be integrated into any mental health training curriculum, and expanded to physicians, nurses, social workers, and others who provide services. Mental health providers should engage in advocacy and work with government officials towards policy changes as well as reduction of stigma in their local and national contexts. Finally, mental health providers may engage in international engagement and outreach to share their expertise with practitioners in other countries that may not have the same resources. We see these steps as necessary to work towards better psychological well-being and health of transgender and gender diverse people internationally.

Disclosure statement

No potential conflict of interest was reported by the authors.

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